CENTRAL ASIA REGION

PEPFAR GENDER ANALYSIS SUMMARY

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Background

At the end of 2013, there were an estimated 1.1 million [0.98 million–1.3 million] PLHIV in Eastern Europe and Central Asia, which accounts for 3% of the global number of PLHIV. In Kazakhstan, official statistics count 18,247 PLHIV; in Tajikistan 5,561 PLHIV are officially registered, with virtually the same number in the Kyrgyz Republic (5,504), although the real population sizes are estimated to be significantly larger due to under-testing of key populations. The HIV epidemic in CAR continues to grow, and is primarily concentrated among people who inject drugs (PWID) and their sexual partners. Sixty percent of the cumulative HIV cases in this region have been reported among PWID. Heterosexual transmission among PWID is known to be of significant importance, but the proportion of sexual transmission independent of drug use is not known. Given that injection drug use is predominantly a male behavior in the region, HIV prevalence is higher among men than women (in Kazakhstan, 62% for men and 35% for women; in Kyrgyzstan, 66% for men and 29% for women; in Tajikistan, 63% for men and 29% for women). However, the proportion of cases of HIV via sexual transmission is increasing, which means that women make up a growing proportion of new HIV cases. A significant portion of the women who acquired HIV through sexual transmission are male PWID's sexual partners.

More conclusive data are needed on the estimated number of females who inject drugs (FWID), but current estimates show that FWID are a much more hidden population, and only a small percentage of them are visible. In a gender assessment in Kazakhstan, female participants said that they estimate that 40% of all PWID are women. Male participants estimated the number of women among PWID to be much smaller, only 15-20%.

The PWID HIV epidemic in Central Asia is largely a result of unsafe drug use such as sharing needles, syringes or injection equipment and risky sexual behaviors. PWID in Central Asia are often sexually active, have multiple sexual partners, have suboptimal condom use, and have high rates of sexually transmitted infections (STI). It is believed that most females living with HIV (FLHIV) in the Central Asia Region acquired the virus either because of their own injection drug use behavior or because their male sexual partners acquired the virus through injection drug use.

Results of the cross-sectional survey among sex partners of PWID suggest that sexual transmission of HIV in the Kyrgyz Republic remains closely related to injection drug use and transmission from PWID. The findings also demonstrate underreporting of previous or current injection drug use as it is a highly stigmatized behavior, especially among women; injection drug use among women may contribute to what appears to be the increased reporting of sexually transmitted HIV infections among all the reported new HIV infections. Furthermore, the data indicate that persons who have multiple sex partners (independent of drug injecting practices) are engaged in unprotected sexual intercourse with HIV-positive PWID or PWID with unknown HIV status and thus, are at particular risk for HIV infection.

The sexual transmission from HIV-positive PWID to their sex partners is facilitated by the fact that many PWID are unaware of their HIV status due to limited access and uptake of HIV testing among this group, and consequently limited use of HIV prevention methods. In addition, according to an ICAP survey in Kyrgyzstan, the majority of PWID with confirmed HIV positive status are not enrolled in care, do not receive antiretroviral therapy (ART), and have a high HIV viral load, which is associated with higher risk of HIV transmission.

In most countries in the region, substitution therapy is either illegal or at the pilot stage and not widely available; harm reduction services have not been widely implemented in the Central Asia. Women especially have limited access to harm reduction services in Central Asia. In addition, criminalization of drug use influences HIV risk and access to services for PWID. It is estimated that between 50% and 75% of PWID in Central Asia have been arrested at some point.

Gender Issues Related to the HIV/AIDS Epidemic among PWID

Cultural and social understandings of gender and femininity in Central Asia are changing. However, sexuality is largely influenced by Islam and local customs throughout Central Asia. For example, women's sexuality is limited to marriage and heterosexual marriage is the cultural norm. Men in post-Soviet Central Asia have seen their gender roles challenged, as they are increasingly unable to provide financially for their families and wives, something that is strongly valued in the ideals of masculinity in the region. These challenges to masculinity are believed to have influenced depression, drinking, drug use, and risky and violent behavior among men. Ideas about masculinity and what it means to be a man dictate how men living with HIV (MLHIV) react to their own risk-taking behaviors and to how they protect their female partners from becoming infected. These concepts of masculinity include ideas such as men always being on the brink of risk, men as the breadwinners, and men making the decisions in the relationships with women, including the sexual aspects.

Conceptions of gender among PWID influence how they perceive HIV risk and risk for drug dependency. Related to norms of masculinity, men who inject drugs (MWID) view themselves as stronger, less likely to get addicted, and needing to protect women in their drug use. MWID also reported that FWID wait until men have injected before taking their turn to check the quality of heroin and the risk of overdose. MWID viewed this as a way of protecting women and also noted that this is indicative of women being weaker. However, women have indicated that waiting for men to inject is a risk reduction strategy for overdose prevention. Outreach workers have reported that women often do not control their safety in using drugs and that men often control drug preparation. An additional risk for FWID is the overlap between drug use and involvement in sex work.

Gender norms also influence the ability of individuals to adopt risk reduction activities, such as condom use and clean needles, and access HIV prevention and treatment services. The main risk factors for women living with HIV in Central Asia include: having a male sexual partner who injects drugs; having a male partner who was incarcerated; or having a male partner who was a migrant worker.

Women who inject drugs

Injection drug use among women is less socially acceptable that among men. This contributes to stigma associated with being a FWID. Women are often introduced to injection drug use by their male sexual partners, and their addiction is often supported by husbands or boyfriends. If the male partner is incarcerated, gets sick, passes away, or otherwise disappears, the FWID are left in a very vulnerable situation. Very often women exchange sexual services for drugs, money, or shelter, but do not necessarily identify as sex workers. In these instances, disclosure of an HIV-positive serostatus would mean the loss of this income and support.

Outreach workers are able to tell more about MWID behaviors. The common perception is that FWID behaviors are not well known because they are a "hidden group." Power, including gender relations, influence HIV risk. Those who have more power inject first, and those who have less power inject last. The power is in the hands of those who have contact with dealers and may provide access to drugs. Usually, it is men who have the power and the access to drug dealers.

Stigma. Females living with HIV are highly stigmatized in part because of the cultural norms surrounding female sexuality that prohibit sexual activity outside of marriage and the belief that people who have HIV acquired it through immoral behavior.

Gender-based violence. Gender-based violence is a major constraint to FWID's and female partners of MWID's ability to protect themselves from HIV risk and to access outreach services. Violence against key populations is often fueled by perceptions of transgression against accepted gender norms and behaviors. For example, FWID are more susceptible to violence than their male counterparts because they are seen as engaging in "unacceptable female behavior." Research indicated that females who inject drugs are subject to violence by their male partners. Intimate partner violence is viewed as a "normal occurrence," especially in Tajikistan. There, FWID report experiencing physical violence from their husbands if they do not obey them, if the husband was not satisfied with the cooking or cleaning, or if he was not satisfied sexually. This has negative consequences on FWID's ability to negotiate safer sex, negotiate safer injection behaviors, and access services. In addition, FWID (and sex workers) often experience violence from police, particularly in Kyrgyzstan.

Condom use. Condom use, especially the woman's ability to initiate condom use with her husband is restricted by the social and cultural norms in Islamic society. In many cases, the predominant social attitude is that a person who uses condoms is not a good or moral person. Women living with HIV have reported that it is nearly impossible or impossible to negotiate condom use with their husbands. Some women are limited in their ability to negotiate condom use with their husbands for fear of negative reactions and violence. Men who live with HIV have said that condom use is difficult to discuss with wives and girlfriends.

Gender norms and gender dynamics influence HIV risk perception, engagement in unsafe sexual and drug using behaviors, and risk for sexual partners. MWID demonstrated insufficient knowledge about HIV and perceived their risk to be low. Outreach workers have also said that MWID may use condoms

with casual partners, but consider condom use with steady partners to be inappropriate. Participants reported having multiple sexual partners.

In an ICAP study of PWID sex partners in Kyrgyzstan, a high percentage of respondents (75.4%) reported never or sometimes using condoms. Regular use of condoms was low; only 24.61% of all respondents indicated they always use condoms with partners who use drugs, and 25.6% indicated they always use condoms with partners who do not use drugs). In Kazakhstan, in a similar study, a high percentage of respondents (70.9%) reported never or sometimes using condoms. The main reasons for not using condoms were significantly different for men and women. Regardless of partner type, men most frequently reported: "I don't like using condoms," while women most frequently reported: "We had no condom with us" and "I fully trust my partner(s)."

First 90 – 90% Diagnosed

According to stakeholders, since FWID remain a largely hidden population, they are more difficult than MWID to reach and establish contact with for HIV prevention activities. This may also be due to the smaller numbers of FWID. In Kazakhstan, out of 800 NGO clients, only 25 were women. Outreach workers report that it is easier to work with MWID because women don't want to reveal themselves, due to stigma. FWID have said that they are reluctant to use prevention services since this means risking disclosure of their drug dependency. FWID have also mentioned that they do not like to take the free syringes and condoms at the AIDS Center because there is a stamp "for free" on them and then people would know that they are participating in HIV prevention programs and their status as drug users would be revealed.

In addition, there are elements of gender relations that constitute significant barriers for FWID's use of HIV prevention services. Men may be reluctant to recognize their wives' addiction and prohibit them from using harm reduction services. Men may prohibit their wives from leaving the home. FWID may fear disclosing their addiction and it may be difficult for them to visit harm reduction services or buy needles and syringes at a pharmacy.

Harm reduction services designed specifically to meet women's needs are lacking. There is a lack of female outreach workers in the NGOs dedicated to working with PWID. One promising approach has been to create separate spaces for FWID and MWID within one NGO. It is especially important for women to have a space that is child-friendly (for example, NGO SPIN+ has created separate drop-in-centers). However, key informants have noted that it may be extremely difficult for FWID to come to an organization that is labeled as being for PWID because of the high levels of stigma associated with being a *female* PWID.

In Tajikistan, opioid substitution treatment (OST) is being piloted, but is not widely available. It is administered primarily to PLHIV. There are no OST programs in prisons or detention centers, so clients who become incarcerated do not continue with the therapy. According to key stakeholders, the country is now at a turning point when it can widely adopt OST or discontinue all programs. There are significantly fewer FWID enrolled in OST programs as compared to MWID. For example, in the main narcology center in Dushanbe, only eight of the one hundred and forty-eight clients are women. Health

care providers said that it is often more difficult for FWID to come to get services due, in part, to: their role as caretakers of children and the home; lack of financial resources for transportation; needing the husband's permission; and the stigma of being a woman using drugs.

HIV testing. In Central Asia, HIV testing is provided at AIDS Centers. Outreach workers refer PWID for testing, and often escort them to the AIDS Center. Outreach workers have reported that it is more difficult to motivate men than women to go for an HIV test. MWID focus group participants said that they are not likely to get tested for HIV and STIs unless there are symptoms. Outreach workers said that the approach they use to increase HIV testing among FWID is to focus on protecting one's family. They report that it is easier for MWID to bring their partners for testing than it is for FWID. This is largely due to the fact that is very difficult for women to disclose their status.

PEPFAR APR data show that many more men are being tested for HIV than women, with 83% being men and 17% female. Data are not disaggregated by PWID, however; it is difficult to know how many of these individuals receiving HIV testing services are the result of community outreach workers for PWID. Positivity data are also lacking, so it is difficult to correlate testing data with treatment data. However, these data indicate that greater efforts should be made to reach women with outreach and HIV testing services.

In Central Asia, many women get diagnosed with HIV during pregnancy. There is limited counseling available at this time, especially if the woman is diagnosed using a rapid test during labor. In Tajikistan, outreach workers report that women often do not go for their test results during pregnancy, that they often call the women and take them to get their results. Also, women who are tested during labor and live in other cities have to wait three to four months for their results because the blood analysis is done in Dushanbe for the entire country. AIDS Center staff mentioned that it is very difficult when a pregnant woman finds out her status, because she is blamed. The main concern among the MLHIV participants was doctors' breach of confidentiality and illegal disclosure of the men's HIV diagnosis.

While counseling is part of the HIV testing protocol, it may not always be carried out effectively and lacks a gender-sensitive approach. In addition, AIDS Center staff in Tajikistan said that intimate partner violence is a problem among their female clients. They said that they do not have time to discuss everything during post-test counseling, that the issue of violence comes up sometimes, but that they do not have the time to ask all of their clients about it.

In an ICAP study of PWID sex partners in Kyrgyzstan, in less than half of participants (44.1%), testing was initiated by healthcare workers during pregnancy, hospitalization or admission to a penitentiary institution. More men than women (76.4% vs 48.0%) were tested for HIV because they wanted to know their HIV status, or because they were referred to a clinic by an NGO.

The main barriers to HIV testing reported by respondents in the ICAP study in Kyrgyzstan were the lack of time to get tested, fear that they would be seen in a testing facility, inconvenient test site operating hours, and fear of knowing their HIV status. Women in particular reported being afraid of stigma and discrimination from medical staff in testing facilities (5% to 2% of men) and that they were afraid someone would see them (9% to 5% of men). Men's largest barriers were a lack of money to get to the

testing facility and reported that it wasn't necessary (21% to 9% of women). However, a significant percentage of respondents (41%) did not report any particular barriers to HIV testing.

WLHIV. Ideas of femininity and what it means to be a woman influence how WLHIV react to their diagnosis and the control they feel that they have over their lives and their risk. For example, women are told that it is their fate to stay with their husbands, that now that they both have HIV and their children have HIV, they are obliged to stay together. Some WLHIV cannot leave their husbands even if they would like to because they are dependent on them financially and for housing. Many of these women do not have more than an eighth-grade education nor do they have employable skills.

WLHIV said that they experience significant levels of stigma and discrimination. The predominant perceived attitude towards them is that: "If she was a good woman, she would not have become infected. It is not a disease of a decent person." WLHIV discussed how the general population has a very low level of knowledge about HIV, think that HIV can be transmitted by air and shared dishes, and that these misperceptions add to society's stigmatization of PLHIV. Fear of stigma and discrimination is so high that this prevents public disclosure of HIV-positive serostatus. While stigma is high for all PLHIV, it is especially severe for women as compared to men, and particularly regarding access to services

Second 90 – 90% on Treatment

Many respondents in Kyrgyzstan said that there is an absence of reliable, national data or tracking of HIV cases among PWID. As such, it is difficult to obtain sex-disaggregated data for PWID receiving ART services. Poor data and surveillance of PWID by sex leads to unaddressed needs. The Kazakhstan gender assessment stated that sex-disaggregated data is needed on enrollment in ART. PEPFAR APR data show that slightly more men are newly on HIV treatment than women (59% men and 41% women), with 54% of men currently on HIV treatment versus 46% women. Given the high levels of men who are being tested for HIV, one would expect more men to be on ART. While further research is needed to examine the positivity rates of women and men being tested to ensure that treatment results are in line with testing results, this initial data confirms global data that show men use health services less than women, including seeking care only once they are very ill (e.g., lower CD4 levels), and have higher mortality.

Respondents in the PEPFAR Kazakhstan gender assessment reported that men and women have equal access to HIV treatment, but gender-specific nuances have not been adequately examined. HIV treatment and care was reported to be accessible to all PWID by the participants. However, the FWID participating in this assessment represented the subpopulation of FWID who are independent and active in receiving services. FWID in the focus group discussion said that they did not see any need for additional care and support specific to women. As one participant explained "What should the difference be? Drug users do not have a gender." It is important to note that only one participant said that she had HIV, so these ideas are largely based on perceptions of needs for HIV treatment and care services. There are issues specific to being a woman and to being a FWID that remain to be addressed in current HIV treatment, care, and support services. In Kazakhstan, the network of women living with HIV identified several needs specifically for women; for example, child care, shelters, infant formula, and family planning for FWID/WLHIV. In addition, NGO outreach workers in Tajikistan report that there are

PLHIV who do not always understand their status; they have female client who are taking medications but are not sure what they are. As such, greater treatment literacy efforts are needed.

As previously mentioned, members of key populations are reluctant to frequent public health facilities because of internal and external stigma and discrimination, which seems to be most acute against FWID. Stigma and discrimination was often cited as a reason for women's reluctance or inability to access HIV/AIDS programs and services. This is related to gender norms that perceive FWID more negatively than MWID because women are expected to be more responsible fulfilling their role as mothers, daughters, wives, and sisters.

Third 90 – 90% Virally Suppressed

As mentioned previously, the lack of reliable data on HIV cases among PWID makes it difficult to obtain sex-disaggregated data for PWID retained on HIV treatment. PEPFAR APR data indicate that in 2015, 52% of male PLHIV were retained and 48% of female PLHIV were retained. The number of men and women retained is far less than the number reported to be currently on HIV treatment. The CAR clinical cascade reveals that female PLHIV are more likely to obtain care and be retained in treatment compared to men; sex-disaggregated data regarding PWID retention is lacking. As such, further research is needed to examine barriers to retention for female and male PWID, and for men in particular. Gender assessment participants said that FWID may not adhere to antiretroviral therapy or opioid substitution therapy regimens because of reluctance to return to the facility for their next course, either due to stigma and discrimination or difficulties related to drug use. Additional analysis is needed to address male PWID's reasons for lack of retention. The Kazakhstan gender assessment determined that sex-disaggregated data is needed on adherence to ARVs.

For PWID, access to harm reduction services is needed to assist them in adhering to ART. Opioid substitution treatment (OST) for PLHIV is shown to be effective in improving patients' health, including retention in HIV treatment. OST programming is at various levels in the region; it is being piloted in Tajikistan, but is not widely available. It is administered primarily to PLHIV. There are no OST programs in prisons or detention centers, so clients who become incarcerated do not continue with the therapy. According to key stakeholders, the country is now at a turning point when it can widely adopt OST or discontinue all programs. There are significantly fewer FWID enrolled in OST programs as compared to MWID. For example, in the main narcology center in Dushanbe, only eight of the one hundred and forty-eight clients are women. Health care providers said that it is often more difficult for FWID to come to get services due, in part, to their role as caretakers of children and the home; lack of financial resources for transportation; needing the husband's permission; and the stigma of being a woman using drugs.

Summary

Gender issues in regard to PWID's HIV vulnerability and access to HIV services have not been given adequate attention in Central Asia. In Kazakhstan in particular, members of key populations and the programming staff who work with them often times do not perceive gender norms and inequalities as affecting their lives. Instead, key populations and staff interviewed often voiced that it was a person's particular personality, or their identity as a PWID, or PLHIV, and not gendered norms and roles, that

affected their risk or access to adequate services. This contrasts with Tajikistan, where the visible subordination and restriction of women is more visible and pronounced. Nonetheless, gender norms and inequalities do shape men's and women's HIV risk and access to services. To the extent that gender has been explicitly articulated within the context of the HIV epidemic on Kazakhstan, it is most articulated in terms of attention to the sex of key populations (for example, males or females who inject drugs) – and/or a focus on women. There is not a readily-available understanding of gender as a social construct that shapes the behaviors of men as well as women, that includes relational power imbalances, and that shapes many social norms and related stigma and discrimination for both male and female PWID.

Developing an understanding of gender dynamics and how they shape the HIV epidemic, and promising practices for addressing them will become increasingly crucial as the epidemic shifts from one characterized by injection drug use to one characterized by sexual transmission. Gender issues are also important to consider given the quickly growing epidemic in the region and that sexual transmission of HIV is increasing. Policies and programs will need to expand to more comprehensively integrate gender into their strategies. For example, gender-based violence is a major barrier to women practicing safe sex or abstaining from sex. However, gender-based violence is not recognized as an HIV-related issue by the government, but one for the legal sphere or women's organizations. Also, gender norms of masculinities and femininities, and gender inequalities, limit condom use by men and women; however, most current programming does not recognize or respond to these gender dynamics. Many participants are not using a gendered-lens to examine their risk assessment, service provision, program design, and implementation.

Gaps and Opportunities for Responding to Priority Gender Issues

Although nascent, there are several important efforts to begin to address the gender-specific needs of PWID. Current PEPFAR-funded programming has initiated using same-sex outreach to reach MWID and FWID. This appears to be an initial, effective component of responding to gender differences. It will be important to monitor if there are sufficient, proportionate numbers of male and female outreach workers to the estimated number of male/female PWID, and to expand this strategy where it's not yet been implemented. It is also important to develop and implement drop-in centers and other female-only spaces and support. In addition, the emerging national network of women living with HIV in Kazakhstan, and their strong links with FWID, provides the potential to build an advocacy base and to develop models of woman-centered care. As promising as these efforts are, current technical and financial support for them appears limited. These nascent efforts would benefit from dedicated technical and financial support to help ensure their development and expansion.

At the same time, minimal attention has been paid to how gender norms affect men's injecting and sexual risk for themselves, or for their female (or male) partners. Related to this, there is almost no discussion or programming related to addressing the gender dynamics of condom use, which is especially important in light of increasing sexual transmission. Research on sexual transmission in the region has focused on male PWID transmission to female partners, and in a few cases, has not even referred to the sex of PWID whose partners are being surveyed.

One area that needs to be improved is getting men to understand that they should consider the risk of HIV for their female partners, that it is not just about their own personal risk. This is an opportunity that should be further integrated into programs with MLHIV, PWID, and incarcerated populations. Women's rights and the protection of female partners need to be strengthened within HIV prevention and outreach activities for key populations.

Prioritized Strategies and Approaches to Addressing Gender Issues

1. Promote understanding of and attention to gender norms, relational dynamics, and gender inequalities within the policy and program agendas of principal stakeholders.
    a. Capacity building
        i. Build a shared understanding of gender norms, relational dynamics, and gender inequalities — and how they increase HIV vulnerability, contribute to stigma and discrimination, and limit prevention, treatment, and care — among all stakeholders.
        ii. Build the skills of implementing partners in gender-responsive data collection, analysis, and use for decision-making.
    b. Generate strategic information
        i. Ensure that sex-disaggregated data continues to be collected and reported.
        ii. Review and/or estimate the numbers of male/female PWID/PLHIV that need specific services, including MAT.
        iii. Analyze existing data to assess differences in women's and men's access to HIV services and retention in HIV services.
        iv. Identify a core set of questions about key gender dynamics affecting access and request partners to report routinely on trends and patterns.
        v. Support and disseminate formative research in priority areas to enhance stakeholder understanding of key gender dynamics shaping HIV responses and to develop gender-informed interventions.

2. Reduce major gender-related barriers to HIV services for key populations by implementing gender-responsive HIV outreach and service models.
    a. Strengthen strategies that respond to gender-related barriers, including stigma and discrimination, to reach PWID with HIV-related services.
        i. Continue and expand outreach strategies designed to address gender barriers to reach male and female PWID/PLHIV.
            1. Increase the number of female outreach workers for PWID.
            2. Develop new approaches for reaching hidden PWID, both male and female. Increase male PWID access and use of HIV-related services.
        ii. Develop a core set of group education modules for outreach workers to use with PWID/PLHIV that include information on gender norms, power inequalities, and relational dynamics.

iii. Develop approaches that more directly address gender dynamics between partners as a key determinant of HIV prevention and access to treatment, care, and support.
    1. Integrate couples counseling and education as a key intervention.
iv. Define a comprehensive package of services that responds to the specific gender-related needs of PWID/PLHIV.
    1. Expand work on FWID, including supporting development of women's rehabilitation and support centers for FWID/WLHIV and access to MAT.
    2. Assess male PWID access and use of HIV-related services; address related barriers to facilitate men's enrollment in ART and retention.

3. Reduce gender-based violence and its role in exacerbating HIV vulnerability and limiting access.
    a. Continue GBV programming through outreach workers, including assessing referral services for their friendliness and accessibility for FWID.
    b. Promote awareness campaigns and policy dialogue about the links between GBV and HIV.

4. Enhance the capacity of key populations to advocate for and lead policy change that advances gender equality in the HIV response.
    a. Build capacity for leadership and advocacy for policy change by PWID/PLHIV.
        i. Support capacity strengthening for networks and organizations of PWID/PLHIV who are marginalized due to gender norms and discrimination.
        ii. Include leadership development and support to women to enable them to engage effectively in policy dialogue and decision-making forums.
        iii. Provide focused support to networks of women living with HIV.

This analysis is a summary of PEPFAR gender assessments and the PEPFAR CAR gender strategy from 2013. They include the following:

Eckman, Anne, Kateryna Maksymenko, and Elizabeth King. 2013. The USAID AIDSTAR-Two Project. *PEPFAR Central Asia Region Gender Strategy: Strategic Opportunities 2013–2020*. Arlington, VA: Management Sciences for Health.

King, Elizabeth, Kateryna Maksymenko, and Eckman, Anne. 2013. The AIDSTAR-Two Project. *Gender Assessment: Access to HIV Services by Key Populations in Kazakhstan*. Arlington, VA: Management Sciences for Health.

King, Elizabeth and Kateryna Maksymenko. 2013. The USAID AIDSTAR-Two Project. *Gender Assessment: Access to HIV Services by Key Populations in Tajikistan.* Arlington, VA: Management Sciences for Health.

Messner, Lyn and Tatiana Kazantseva. 2013. *Gender Assessment: Access to HIV Services by Key Populations in Kyrgyzstan*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Updated information has been included from the following sources:

Deryabina, Anna and Aijan Dooronbekova. 2015. *An Integrated Biological Behavioral Survey Among Sex Partners of People Who Inject Drugs in the Republic of the Kyrgyz Republic*.

Deryabina, Anna and Valeria Kryukova. 2014. *An Integrated Biological Behavioral Survey Among Sex Partners of People Who Inject Drugs in the Republic of Kazakhstan.*